



Medicaid Management Information Systems
Maine Integrated Health Management Solution
Health PAS Online: Institutional Claim Submission
and Claim Status User Guide

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By accessing the Maine Health PAS Online Portal, all users agree to protect the privacy and security of the data contained within as required by law. Access to information on this site is only allowed for necessary business reasons, and is restricted to those persons with a valid user name and password.

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1. Introduction

Using the Maine Integrated Health Management Solution (MIHMS) Health PAS Online Portal (online portal), MaineCare providers can quickly and easily enter professional, institutional, and dental claims. This guide will walk the user through the process of entering an institutional claim and modifying it as necessary.

***HINT:** If the user is not already a registered Trading Partner, click this link to the [Trading Partner User Guides](#) for more information.*

2. Information Needed

Before beginning the claims submission process, it will be useful to have the following information, forms, and other documents on hand:

- Verify that the recipient is eligible on the date of service for the services rendered.
- Medicaid is always the payer of last resort. If the member has Medicare or third party insurance, bill them first before billing Medicaid.
- Gather complete member, provider and service information associated with the claim.

3. System Requirements

To successfully use all features of the online portal, ensure that computer systems meet the following minimum requirements:

- Reliable online connection
- Web browser - The online portal supports the following browser types and versions:
 - Microsoft Internet Explorer versions 8, 9, and 10
 - Mozilla Firefox versions 33 and 34
 - Google Chrome version 39
- The latest version of Adobe Acrobat Reader

4. Form Entry: Claim Submission

To begin a claim submission, click the **Claim Submission** link located below the Form Entry heading on the portal links. Now the Submit Claim – Find Member screen will display.

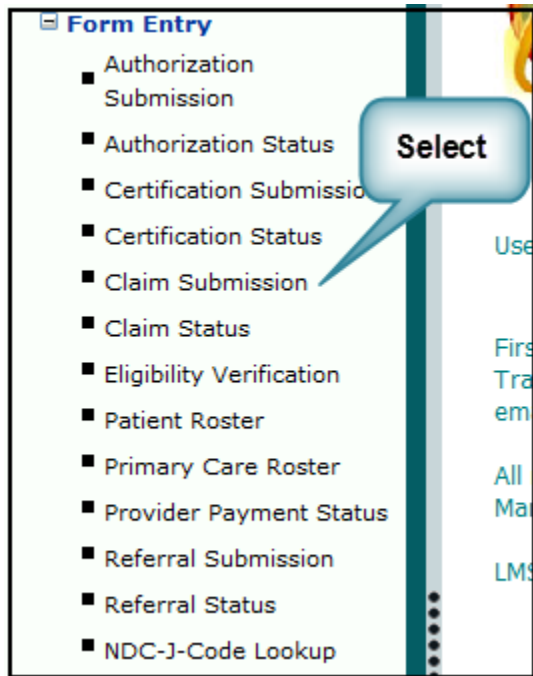


Figure 4-1: Claim Submission

The **Submit Claim** button is also available directly from the Eligibility Verification, Patient Roster, and Primary Care Roster screens as shown in [Figure 4-1](#) above.

The Submit Claim function uses a wizard to guide the user through the steps of the process. The wizard starts with Find Member, as shown in [Figure 4-2](#) below.

4.1 Step 1– Find Member

A screenshot of the 'Find Member' screen within a web application. The title bar at the top says 'You Are Here: Submit Claim - Find Member'. Below the title bar, there is a 'Select Billing Provider:' dropdown menu. Underneath that is a 'Select a Claim Type:' section with three radio buttons: 'Professional', 'Dental', and 'Institutional', with 'Institutional' being selected. A 'Find Member' button is located below the radio buttons. Below the button, there is a text instruction: 'To search for a member, enter search criteria in any two rows. For example enter the Name (last and first) and the Date of Birth.' There are four input fields: 'Member ID:', 'Name (Last and First):', 'Date of Birth: MM/DD/YYYY', and 'Social Security Number: ###-##-####'. The 'Name' and 'Date of Birth' fields are separated by the word 'And'. At the bottom right, there are 'Submit' and 'Reset' buttons.

Figure 4-2: Find Member

Use the instructions below to execute a member search associated with a claim submission.

1. If there is more than one **Billing Provider** associated with the Trading Partner ID, click the drop-down menu to select the proper Billing Provider from the pre-determined list. [Figure 4-3](#) below, shows an example of a Billing Provider drop-down menu.

A screenshot of a web form showing a dropdown menu labeled "Select Billing Provider:". The dropdown is currently closed, showing a blank space and a small arrow icon on the right.

Figure 4-3: Select Billing Provider

2. Select the proper claim type by clicking the radio button next to the “Institutional” option.
3. Enter member search criteria. Two of the four available search criteria fields must be filled for a successful member search:
 - Member ID
 - Name (Last and First)
 - Date of Birth
 - Social Security Number

Additional details on entering search criteria for the member search:

- The **Last Name** and **First Name** count as one search criterion.
 - On the search screen, enter the Last Name in the first field and the First Name in the second field- see [Figure 4-2](#) above.
 - Names must match exactly for the first five letters of the last name and the first three letters of the first name.

***HINT:** If no match is found, try fewer criterions. For example: Kaitlyn Jones-Davis could be entered as Jones for the last name and Kai as the first name. Alternatively, do not use the name criteria, but MaineCare ID and Date of Birth.*

- The **Date of Birth** must be entered in the MM/DD/CCYY format.
 - For example, February 14th, 2008 would be entered as “02/14/2008”.
- The **Social Security Number** should be entered without any dashes.

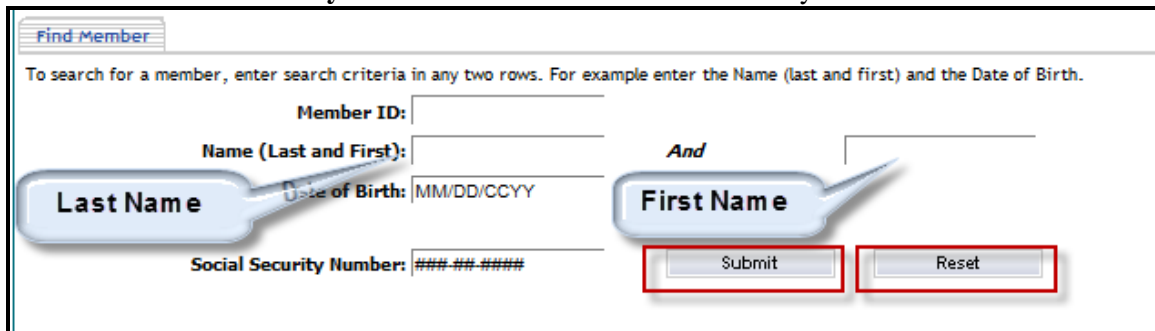
A screenshot of the "Find Member" search form. The form has a title "Find Member" and a subtitle "To search for a member, enter search criteria in any two rows. For example enter the Name (last and first) and the Date of Birth." Below the subtitle are four input fields: "Member ID:", "Name (Last and First):", "Date of Birth: MM/DD/CCYY", and "Social Security Number: ### ## ####". The "Name (Last and First)" field is split into two parts: "Last Name" and "First Name", separated by the word "And". There are "Submit" and "Reset" buttons at the bottom right. Callout boxes highlight the "Last Name" and "First Name" fields.

Figure 4-4: Member Search

4. Select the **Submit** button to perform a search.
 - a. To start the search over, select the **Reset** button to clear all the values entered in the Find Member search fields- see [Figure 4-4](#) above.
5. The search results are returned under the Find Member Results tab, as depicted in [Figure 4-5](#) below. The results will include a list of all the members that meet the search criteria. It will display their Name, Gender, and Date of Birth.
 - a. **If the search returns multiple results**, select the correct member by clicking the checkbox in front of that member’s name as shown in [Figure 4-5](#) below. Click **Continue**.

- b. **If the member is not returned in the search**, click the **Cancel** button to reset and clear all the values entered in the find member search. See the hint under Step 3.

The screenshot shows a web interface titled "Find Member Results". It contains a table with three columns: "Name", "Gender", and "Date of Birth". Below the table, there is a "Select" button with a callout icon pointing to it. To the right of the table, there are two buttons: "Continue" and "Cancel". The "Cancel" button is highlighted with a red rectangle.

Figure 4-5: Member Search Results

4.2 Step 2 – Institutional Claim Submission

The institutional claim type is used to bill for services provided by institutions such as hospitals, Nursing Facilities, Private Non-Medical Institutions (PNMIs), Home Health Agencies, etc. (UB-04). There are six different parts to this claim as shown in [Figure 4-6](#) below: **Claim Information; Admission Data; Diagnosis, Visit and Injury; Procedures; Condition, Occurrence, and Value Codes; Service Codes.**

Claim Information

Billing Provider: Patient Account #*:
Member Name: Medical Record #:
Date of Birth:
Member ID:
Referring Provider: Bill Type*:
Service Location*:
NOTE: You may enter either the Provider's NPI or Medicaid ID
Attending: Other:
Operating: Other:
Covered Days: Life-time Reserved:
Non-Covered Days: Co-insured Days:

Admission Data

Admission Date: Admission Time: Admission Type Code:
Admission Source Code: Discharge Time: Patient Status Code:

Diagnosis

Code Version*: ☐ ICD - 9 ☐ ICD - 10 [CMS claims guidelines for implementing ICD-10](#)
NOTE: At least one Principle Diagnosis code is required

Code	Description	Type	POA	ICD Version
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Reason for Visit

Code	Description	Type	ICD Version
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

External Cause of Injury

Code	Description	Type	POA	ICD Version
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Principle Procedure

Code	Description	Date	Type	ICD Version
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other Procedures

Code	Description	Date	Type	ICD Version
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Condition Codes

Code	Description
<input type="text"/>	<input type="text"/>

Occurrence Span

Code	Description	Date From	Date Thru
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Occurrence Codes

Code	Description	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Value Codes

Code	Description	Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>

Service Codes

☐ Enter NDC Codes

Line#	Code*	HCPCS	Modifier(s)	DOS From*	DOS To*	Units*	Charge*	Non-Covered Charges	Auth #
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Service Code Description:

Claim Header Total: 0
Units: 0
Claims Line Total: 0
Disallowed: 0

[Enter COB Information](#)


Figure 4-6: Institutional Claim

Input fields with a red asterisk (*) are required. An error message will be displayed if these values are left blank.

NOTE: Always tab through fields on a single line (such as in the Procedures Section) to ensure proper completion.

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Some claim items, like occurrence codes, value codes, condition codes, diagnosis codes, procedure codes and service detail may have additional lines added. To add more lines tab through the last line. In order to

delete a line, select the option button  in front of the line.

Proceed through the sections below to complete this screen.

4.2.1 Complete the Claim Information Section

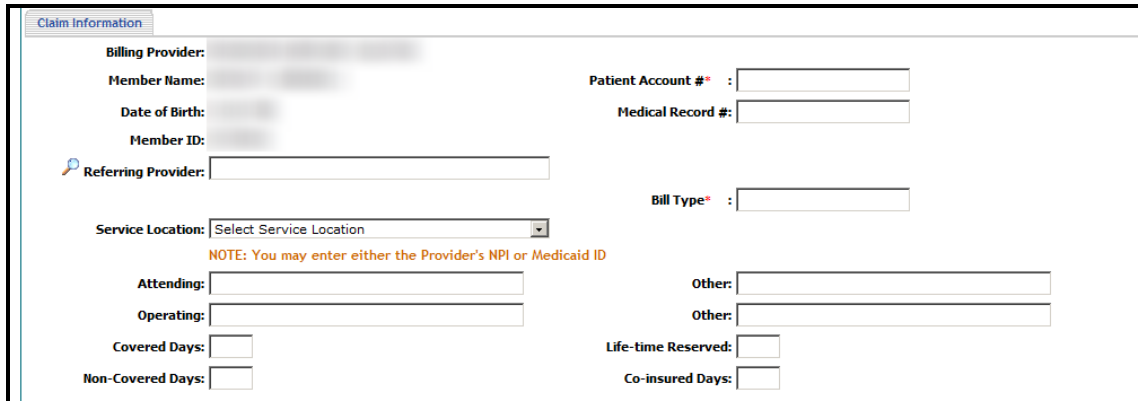


Figure 4-7: Institutional Claim Information

[Table 1](#) below, supplies descriptions and instructions for each field shown in [Figure 4-7](#) above. Use it to complete this section.

Table 1: Claim Information

Field Name	Field Description
Referring Provider	Enter the referring provider by using the look up function. For additional instructions on how to use the provider look up function go to Section 4.2.1.1: Provider Look Up Function .
Service Location	<p>This field is required if the provider is enrolled with more than one service location.</p> <p>Enter the billing provider service location by selecting the drop-down arrow and clicking on the appropriate option.</p> <p>The drop-down selection for this field will show a list of locations if the provider has more than one service location.</p>
Attending	<p>Enter the attending physician. This must be a Type 1 National Provider Identifier (NPI.)</p> <p>NOTE: The rendering provider information goes in the "Attending" field.</p>
Operating	Enter the operating physician.

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Field Name	Field Description																												
Covered Days	The number of days covered by MaineCare as qualified by the payer. NOTE: Do not enter this information under the value code section.																												
Non-Covered Days	Days of care not covered by MaineCare. NOTE: Do not enter this information under the value code section.																												
Patient Account #	This field is required. The alpha numeric information assigned by the Provider that is returned on any Remittance Advice (RA).																												
Medical Record #	The alpha numeric information assigned by the Provider.																												
Bill Type	<p>This field is required.</p> <p>Enter the four-digit code from the National UB-04 manual for the provider type that indicates the type of bill using the following guidance by Provider Type.</p> <table border="1"> <tbody> <tr> <td>Hospital</td><td>011x, 012x, 013x, 014x, or 018x</td></tr> <tr> <td>Critical Access Hospital</td><td>011x, 018x or 085x</td></tr> <tr> <td>Nursing Facility</td><td>021x, 022x or 023x</td></tr> <tr> <td>Nursing Facility (ICF-IID)</td><td>021x or 022x</td></tr> <tr> <td>Home Health</td><td>032x or 034x</td></tr> <tr> <td>ICF-IID</td><td>021x or 022x</td></tr> <tr> <td colspan="2">PNMIs</td></tr> <tr> <td>Appendices C and F</td><td>065x or 066x</td></tr> <tr> <td>Appendices B, D, and E</td><td>086x</td></tr> <tr> <td>Rural Health Center (RHC)</td><td>071x</td></tr> <tr> <td>Freestanding Renal Dialysis Center</td><td>072x</td></tr> <tr> <td>Federally Qualified Health Center (FQHC)</td><td>077x</td></tr> <tr> <td>Hospice</td><td>081x or 082x</td></tr> <tr> <td>Alternative Residential Facility (Formerly AFCH)</td><td>089x</td></tr> </tbody> </table>	Hospital	011x, 012x, 013x, 014x, or 018x	Critical Access Hospital	011x, 018x or 085x	Nursing Facility	021x, 022x or 023x	Nursing Facility (ICF-IID)	021x or 022x	Home Health	032x or 034x	ICF-IID	021x or 022x	PNMIs		Appendices C and F	065x or 066x	Appendices B, D, and E	086x	Rural Health Center (RHC)	071x	Freestanding Renal Dialysis Center	072x	Federally Qualified Health Center (FQHC)	077x	Hospice	081x or 082x	Alternative Residential Facility (Formerly AFCH)	089x
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Freestanding Renal Dialysis Center	072x																												
Federally Qualified Health Center (FQHC)	077x																												
Hospice	081x or 082x																												
Alternative Residential Facility (Formerly AFCH)	089x																												
Other	These fields are not used.																												

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Field Name	Field Description
Life-time Reserved	<p>Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.</p> <p>If the MaineCare member has Medicare as the primary payer and the inpatient hospital situation above has occurred, enter the number of lifetime reserve days that have been met.</p> <p>NOTE: Do not enter this information under the value code section.</p>
Co-insurance Days	<p>The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness.</p> <p>If the MaineCare member has Medicare as the primary payer and inpatient situation above occurs, enter the number of co-insurance days.</p> <p>NOTE: Do not enter this information under the value code section.</p>

NOTE: Portions of the information on this screen will be pre-populated based on the member selection and the trading partner submitting the claim.

4.2.1.1 Provider Look Up Function

To access the provider look up function click on the  icon next to a provider information field. The **Find a Provider** screen will populate with provider search criteria as depicted in [Figure 4-8](#) below.

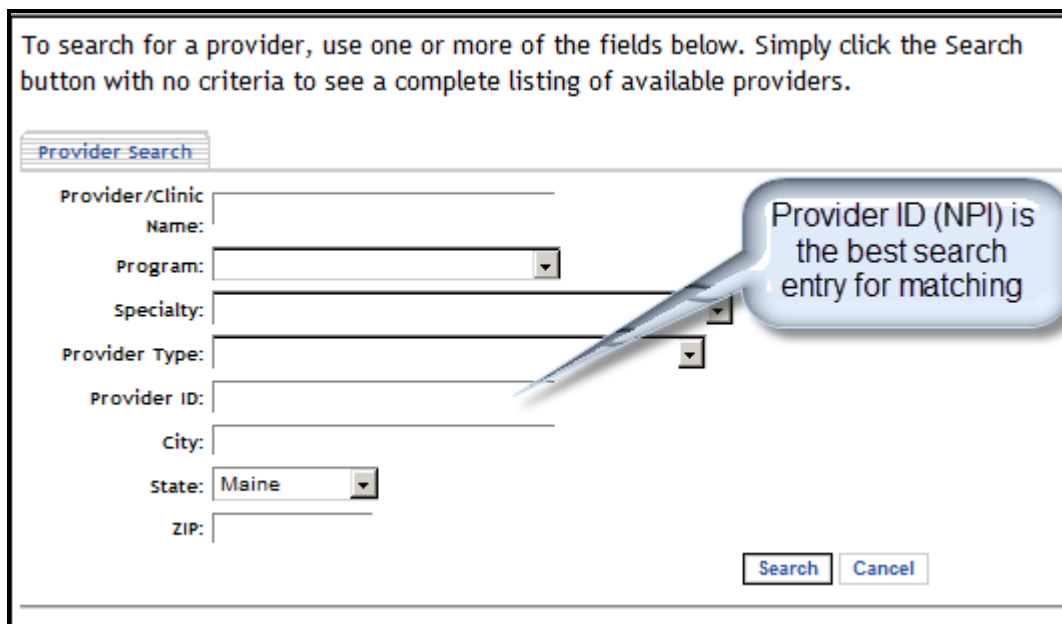


Figure 4-8: Provider Search

NOTE: To search for a provider, use one or more of the fields or click the search button with no criteria to see a complete listing of available providers.

1. Enter the search criteria.
 - a. Drop-down boxes are used to select values for **Specialty**, **Provider Type**, **Program**, and **State**.
 - b. Some lists may have a blank line to allow searching all data.
 - c. All other fields must match exactly for this search function.
2. Click the **Search** button. The results will be listed at the bottom of the **Provider Search** page, under **Search Results**.
3. The results will display the provider's name, provider ID, address, phone number, specialty, and provider type as depicted in [Figure 4-9](#) below.
4. Select the radio button next to the **Provider Name** and click **Continue** to return to the **Claim Information** page.

Name	Provider ID	Address	City, State, ZIP	Phone #	County	Primary Specialty	Provider Type
<input type="radio"/>							

Continue

Figure 4-9: Provider Search Results

4.2.2 Complete the Admission Data

Complete the Admission Data section as depicted in [Figure 4-10](#) below.

Admission Date:		Admission Time:		Admission Type Code:	
Admission Source Code:		Discharge Time:		Patient Status Code:	

Figure 4-10: Institutional Admission Data Section

[Table 2](#) below, supplies descriptions and instructions for each field. Use it to complete this section:

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Table 2: Claim Admission Data

Field Name	Field Description
Admission Date	<p>If provider type is listed below, this field is required.</p> <ul style="list-style-type: none"> Enter the date the member was admitted to the facility if the provider type is: <ul style="list-style-type: none"> Alternative Residential Facility Hospice Hospital Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Nursing Facility Private Duty Nursing Private Non-Medical Institution (PNMI) Psychiatric Facility Enter the date this episode of care began if the provider type is: <ul style="list-style-type: none"> Home Health <p>Dates must be entered in MM/DD/CCYY format. For example, February 14, 2008 would be entered as "02/14/2008".</p>
Admission Time	<p>This field is required for inpatient hospital bills only (except Type of Bill 012x).</p> <p>Enter the two-digit code indicating the hour that the patient was admitted from inpatient care.</p> <p>Refer to the National UB-04 manual for specific codes.</p>
Admission Type Code	<p>This field is required.</p> <p>Enter the admission type.</p> <p>Refer to the National UB-04 manual for specific codes.</p>
Admission Source Code	<p>Situational. This field is required for inpatient and outpatient hospital bills and for some Medicare claims.</p> <p>Enter the source of admission.</p> <p>Refer to the National UB-04 manual for specific codes.</p> <p>Do not enter an admission source for an outpatient claim, except when billing secondary to Medicare for outpatient diagnostic testing services.</p>
Discharge Time	<p>This field is required for inpatient hospital bills only (except for Type of Bill 012x).</p> <p>Enter the code indicating the hour that the patient was discharged from inpatient care.</p> <p>Refer to the National UB-04 manual for specific codes.</p>
Patient Status Code	<p>This field is required.</p> <p>Enter a code indicating patient status as of the ending service date of the period covered on the bill.</p> <p>Refer to the National UB-04 manual for specific codes.</p>

4.2.3 Complete the Diagnosis Section

Complete the Diagnosis Section as depicted in [Figure 4-11](#) below. The diagnosis section is used to enter the diagnoses associated with the services provided to the member.

This section of the institutional claim screen has four subsections (**Diagnosis**, **Admitting Diagnosis**, **Reason for Visit**, and **External Cause of Injury**). Complete each subsection by typing in the diagnosis code or by using the diagnosis search function.

NOTE: Effective on 10/1/2015, providers will be able to enter both ICD-9 and ICD-10 based claims. The following changes to the portal will be available:

- ICD-9 and ICD-10 radio buttons will be provided in diagnosis code session. Selection of one radio button will be required to differentiate between ICD-9 and ICD-10 based claims. A diagnosis code cannot be entered before one of the ICD radio buttons is selected. After a diagnosis code is entered, the ICD radio button selection cannot be changed.
- A link called 'CMS Claims Guidelines for Implementing ICD-10' will be available to the right of the ICD radio button selection if additional ICD-10 information is needed.

Instructions for using the diagnosis search function are outlined in [Section 4.2.3.1: Diagnosis Search Function](#).

The screenshot displays the 'Institutional Diagnosis Section' of the Health PAS Online portal. It features four main subsections: 'Diagnosis', 'Admitting Diagnosis', 'Reason for Visit', and 'External Cause of Injury'. Each subsection contains a table with columns for 'Code', 'Description', 'Type', 'POA', and 'ICD Version'. The 'Diagnosis' subsection is the primary focus, showing a 'Code Version' dropdown set to 'ICD-9' and a link to 'CMS claims guidelines for implementing ICD-10'. A red note indicates 'At least one Principle Diagnosis code is required'. A search icon is located in the first row of the 'Diagnosis' table, with a callout box pointing to it that says 'Click to Search for Code'.

Figure 4-11: Institutional Diagnosis Section

Use the bulleted tips below to complete this section:

- Enter at least one **Diagnosis** (primary/principal diagnosis) in the Diagnosis subsection (see note above about the ICD code selection). The primary or principal diagnosis code must be the reason shown in the medical records as being chiefly responsible for the service being provided.
- An **Admitting Diagnosis** is required on inpatient admissions.
- A **Reason for Visit** diagnosis is required for all unscheduled outpatient visits. Unscheduled outpatient visits are defined as TOB 013x or 085x with a priority of admission of 1, 2, or 5 and revenue codes of 045x, 0516, 0526 or 0762.
- When an injury is the result of an external cause rather than an illness or disease (i.e. motor vehicle accident, fall, poisoning, etc.), use the **External Cause of Injury** subsection to enter the appropriate diagnosis.
- MaineCare does not use the POA at this time, but providers may include it if desired. POA is required for hospitals.
- Providers, such as an Alternative Residential Facility, that do not have a primary diagnosis code, please ask the member's physician or caseworker.


- Enter the ICD-9-CM or ICD-10-CM diagnosis code or codes that identify any additional conditions that co-existed at the time of admission, or any conditions that developed subsequently, and that affected the treatment received or the length of stay.

NOTE: For most bill types, services before and on or after 10/01/2015 need to be billed on separate claims. Claims with dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. Claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code.

Claims with services before and on or after 10/01/2015 can be billed on the same claim form if the type of bill is 011X, 018X, 021X, or 032X. If the claim has a discharge and/or through date on or after 10/01/2015, the entire claim is billed using ICD-10-CM codes.

- Hospitals must use appropriate diagnosis codes when billing for serious reportable events.

4.2.3.1 Diagnosis Search Function

To access the **Diagnosis Codes** search function, click on the  icon, as shown in [Figure 4-11](#) above, and a new search window will open, as shown in [Figure 4-12](#) below.

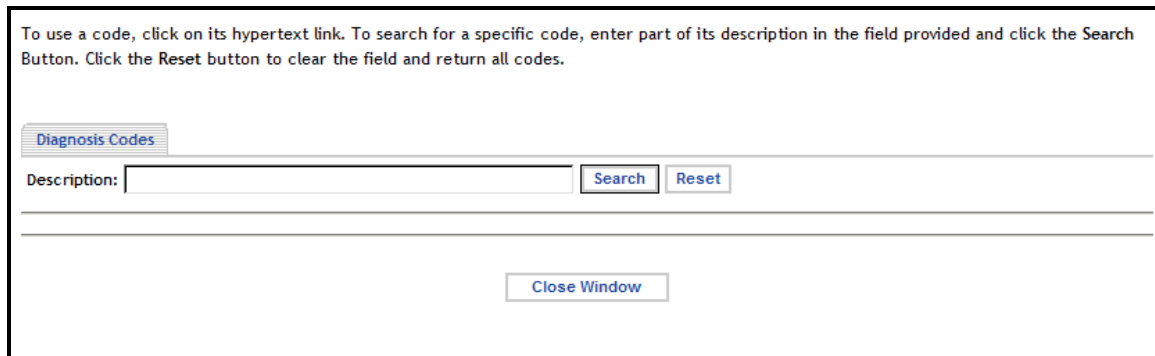


Figure 4-12: Diagnosis Search Function

1. Enter any part of the description of the code in the **Description** field.

HINT: MIHMS will match exactly the sequence of characters entered in the search criteria, for example: if no match is found for “Sleep Disorder” try just “sleep”. Conversely, using just the word “disorder” may be too broad and result in a longer list.

2. Click the **Search** button to get a list of results. The system will look for the text entered regardless of where it falls in the description.
 - To start over, click the **Reset** button to clear the **Description** field.
3. The diagnosis search results will display **Code IDs, Descriptions, Effective Date, Term Date (if applicable), and ICD Version**. Click any **Code ID** link to populate the Code ID to the **Diagnosis** section- see [Figure 4-13](#) below, for reference.

NOTE: Effective on 10/01/2015, the Code ID displayed in the search field will be based on the ICD-radio button selection made as part of the steps listed in section [4.2.3](#). For example, if a user chose the ICD-10 radio button, only ICD-10 codes will display in the Code ID field.

4. Once the Code ID is displayed, tab through to populate the description. A new line will be presented if additional codes need to be entered.
 - a. Additional blank lines will not affect the processing of the claim.

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To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

Diagnosis Codes

Description:

Code ID	Description	Effective Date	Term Date	ICD Version
F10.180	Alcohol abuse w/alc-ind anxiety disorder	10/1/2013		10
F10.181	Alcohol abuse w/alc-ind sexual dysfunction	10/1/2013		10
F10.182	Alcohol abuse w/alc-induced sleep disorder	10/1/2013		10

Figure 4-13: Institutional Diagnosis Search Results

NOTE: Ambulance claims must include a diagnosis code. For dates of service prior to 10/01/2015, use ICD-9 code 780.99 (Other General Symptoms). For Dates of Service of 10/01/2015 and forward, use the appropriate ICD-10 code: R45.84 (anhedonia) or R68.89 (other general symptoms and signs).

4.2.4 Complete the Procedures Section

Complete the Procedures section as depicted in [Figure 4-14](#) below. This section of the institutional claim screen has two subsections (**Principle Procedure** and **Other Procedures**). Complete each subsection by typing in the procedure code or by using the procedure search function.

Instructions for using the procedure search function are outlined below.

NOTE: Additional information on covered services can be found in the *MaineCare Benefits Manual*.

Principle Procedure **Other Procedures**

Code	Description	Date of Service	Type
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>


Code	Description	Type
<input type="text"/>	<input type="text"/>	<input type="text"/>

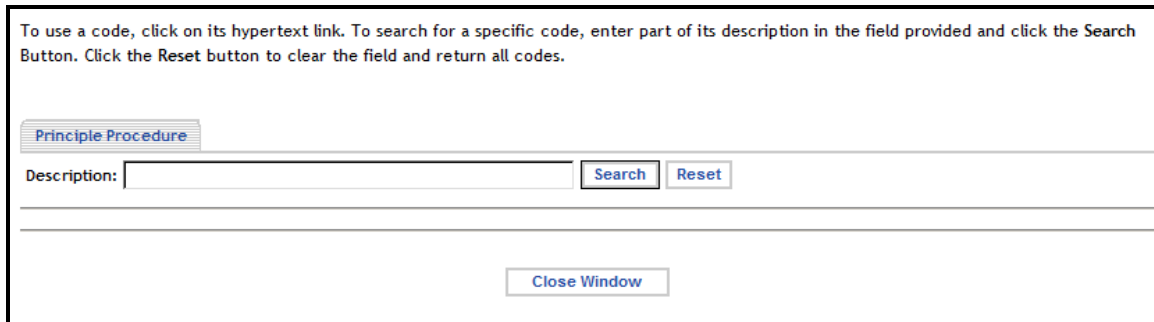
Figure 4-14: Institutional Procedure Section

Use the bulleted tips below to complete this section:

- The completion of at least one procedure code is required if the claim shows that Hospital-Inpatient services were performed.
- If a procedure code is not required (for example, on outpatient claims) do not populate the field.
- If applicable, enter the code that identifies the principal procedure. Enter the date in eight-digit format (MM/DD/CCYY).
- The first procedure entered under the **Principle Procedure** subsection will be automatically considered the primary procedure. Any additional procedures that are entered will be considered secondary.
- If the procedure is for sterilization or abortion, the principle procedure must agree with the diagnosis.
- Enter a code identifying any other significant procedures other than the principal procedure in the **Other Procedures** subsection. Enter the date in eight-digit format (MM/DD/CCYY).

4.2.4.1 Procedure Search Function

To access the Procedure code search function, click on the  icon, as shown in [Figure 4-14](#) above, and a new search window will open.



To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

Principle Procedure

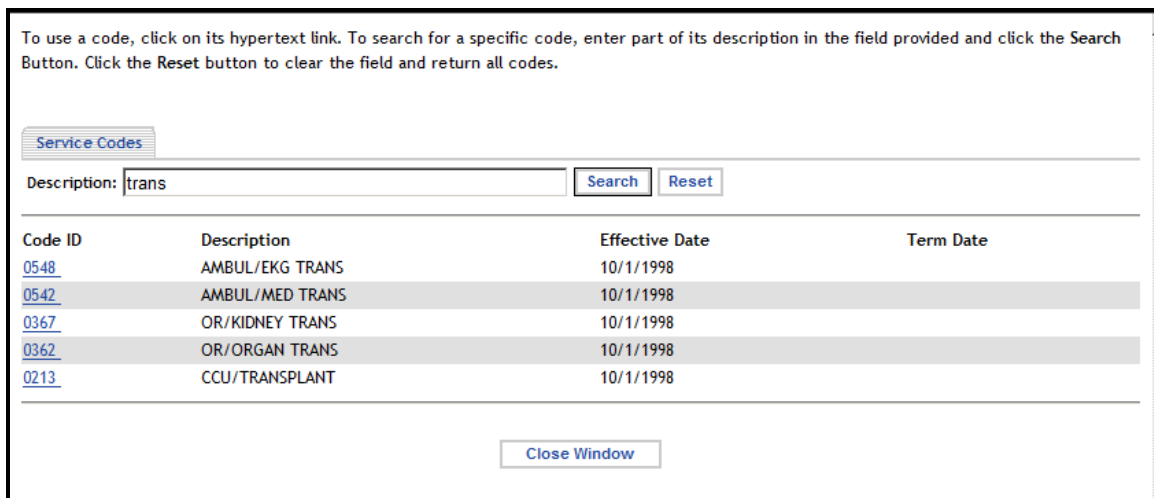
Description:

Figure 4-15: Procedure Search Function

1. Enter any part of the description of the code in the **Description** field- see [Figure 4-15](#) above for reference.

HINT: MIHMS will match exactly the sequence of characters entered in the search criteria, for example: if nothing is found for “Cardiac Surgery” try just “cardiac”. Conversely, using just the word “surgery” may be too broad and result in a longer list.

2. Click the **Search** button to get a list of results. The system will look for the text entered regardless of where it falls in the description.
 - To start over, click the **Reset** button to clear the **Description** field.
3. The procedure search results will display **Code IDs, Descriptions, Effective Dates, and Term Dates (if applicable)**. Click any **Code ID** link to populate the Code ID to the **Procedure** section- see [Figure 4-16](#) below for reference.



To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

Service Codes

Description:

Code ID	Description	Effective Date	Term Date
0548	AMBUL/EKG TRANS	10/1/1998	
0542	AMBUL/MED TRANS	10/1/1998	
0367	OR/KIDNEY TRANS	10/1/1998	
0362	OR/ORGAN TRANS	10/1/1998	
0213	CCU/TRANSPLANT	10/1/1998	

Figure 4-16: Procedure Search Function Results

NOTE: Tab through the procedure fields to populate the procedure description once the procedure is selected.

4.2.4.2 Complete the Condition, Occurrence, and Value Codes

These sections of the institutional claim screen require a **Code** and a **Description** that can be completed by manual entry or by using the search function as depicted in [Figure 4-17](#) below.

The screenshot displays four sections of the institutional claim screen, each with a table for entering codes and descriptions. The sections are:

- Condition Codes:** A table with columns 'Code' and 'Description'.
- Occurrence Span:** A table with columns 'Code', 'Description', 'Date From', and 'Date Thru'. A red box highlights the search icon in the 'Code' column, and a blue callout bubble points to it with the text 'Click to search'.
- Occurrence Codes:** A table with columns 'Code', 'Description', and 'Date'.
- Value Codes:** A table with columns 'Code', 'Description', and 'Amount'.


Figure 4-17: Condition, Occurrence and Value Codes Section

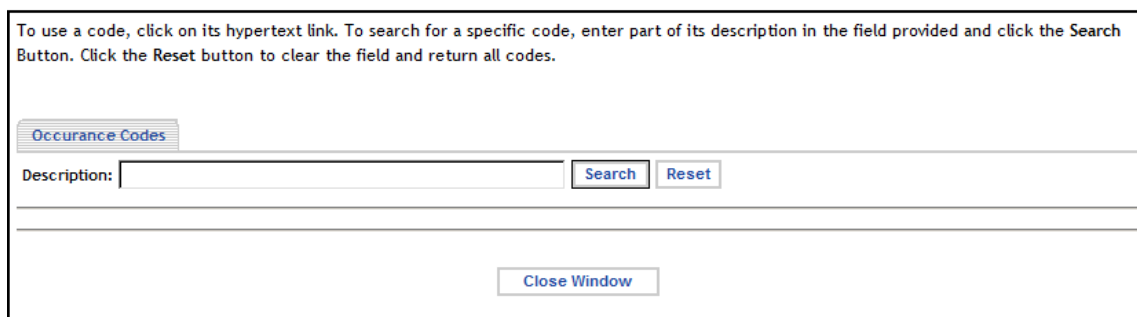
Use the bulleted tips below to complete this section:

- For Condition Codes:
 - In the condition code field, enter codes used to identify conditions relating to the bill that may affect payer processing.
 - Three condition codes with special significance are:
 - Use Code AJ for services, including emergency services, to bypass the MaineCare co-pay requirement (as allowed by the *MaineCare Benefits Manual*).
 - Always use Code A1 to identify an EPSDT–related claim.
 - Use B3 (Pregnancy Indicator) to bypass the MaineCare copay requirement (as allowed by the *MaineCare Benefits Manual*).
- For Occurrence Span Codes:
 - If applicable, enter a code and related dates that identify an event that spans time and relates to the payment of the claim.
 - To bill for services not covered by Medicare, use the occurrence span code 74 with the occurrence span dates which encompass the to and from dates of service being billed on the claim. The span code 74 indicates Medicare will not pay for the level of care needed for the member.
- For Occurrence Codes:
 - If applicable, enter the code and associated date defining a specific significant event relating to the bill that may affect payer processing.
 - Ex. Jan 5-10 Medicare Benefits exhausted (A3).
 - Ex. The date active care ended (22).
- For Value Codes:
 - If a MaineCare patient has Medicare as the primary payer, or is responsible for a Spenddown amount, enter that information in the Value Codes area. In the Code field, use the following:
 - A1 = Deductible Payer A (B1, C1 ...)
 - A2 = Coinsurance and/or Copayment Payer A (B2, C2 ...)

- 66 = Medicaid Spenddown amount
 - A7 = Co-Payment Payer A (B1, C1, ...)
 - Do not use codes 80, 81, 82, or 83 as these details will be entered in [Section 4.2.1: Complete the Claim Information Section](#) for the “covered days” (code 80), “non-covered days” (code 81), “lifetime reserve days” (code 82), and “co-insured days” (code 83).
 - Refer to the National UB-04 manual for complete instructions and specific codes.
 - In the Amount field, enter the amount.
 - Do not enter other third party co-insurance/ deductible.
 - On all claims do not enter a patient assessment/cost of care.
- General Tips:
 - Refer to the National UB-04 manual for the full list of specific codes.
 - Both the Occurrence areas require **Dates** (MM/DD/CCYY). The Value Code requires an **Amount**.

4.2.4.3 Code Search Function

To search for a **Code** select the  icon and a new search window will open as seen in [Figure 4-18](#) below. The occurrence code search will function as an example.



To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

Occurance Codes

Description:

Figure 4-18: Occurrence Code Search Function

1. Enter any part of the description of the code in the **Description** field.
2. Click the **Search** button to get a list of results. The system will look for the text entered regardless of where it falls in the description.
 - To start over, click the **Reset** button to clear the **Description** field.
3. The code search results will display **Code IDs, Descriptions, Effective Dates, and Term Dates (if applicable)**. Click any **Code ID** link to populate the Code ID to the **Condition Code** section as shown in [Figure 4-19](#) below.

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To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

Condition Codes

Description:

Code ID	Description	Effective Date	Term Date
A0	TRICARE External Partnership Program	1/1/1980	

Figure 4-19: Condition Code Search Function Results

4.2.5 Complete the Service Codes Section

Complete the Services section as depicted in [Figure 4-20](#) below.

Service Codes

☐ Enter NDC Codes

Line#	Code *	HCPCS	Modifier(s)	DOS From *	DOS To *	Units *	Charge *	Non-Covered Charges	Auth #
1									

Service Code Description:

Claim Header Total: 0
Units: 0
Claims Line Total: 0
Disallowed: 0

Figure 4-20: Institutional Services Section


This section of the claims screen is used to enter the Services rendered to the member that will be included in the claim submission. The fields and links associated with this section are summarized in [Table 3](#) below.

If a member has a coverage code of "Spenddown", the Spenddown letter must be obtained and attached to the claim- see [Section 4.3.4: Upload Attachments](#) for more information. Spenddown claims are entered via Direct Data Entry (DDE) according to the usual institutional claim entry instructions in this guide in [Section 4: Form Entry: Claim Submission](#)

Table 3: Claim Service Code Section

Field Name	Field Description
Enter NDC Codes	Select the Enter NDC Codes check box to enter a service line for physician administered drugs. This action will make the following fields on the service line editable: <ul style="list-style-type: none">• NDC• Unit of Measure• Quant/Units• Rx Number

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Field Name	Field Description
	Click this icon to delete a service line.
Line #	<p>This is a system-generated field used to number each service line added by the user.</p> <p>To add a new service line, hit tab at the end of the last line and a new line will appear.</p>
Code	<p>This field is required.</p> <p>Enter a four-digit code that identifies a specific accommodation, ancillary service, or billing calculation.</p> <ul style="list-style-type: none"> ○ See the National UB-04 manual for specific codes or use the Revenue Code look up function. ○ For additional instructions on how to use the Revenue Code look up function, go to the Revenue/Service Code Search Function section below. <p>For more detailed information regarding Nursing Home and PNMI billing, and for rate and Resource Utilization Groups, see Appendix A: Additional Revenue Code Information</p>
Service Code Description	<p>This field will automatically populate.</p> <p>Shows the description of the revenue code entered for the specified service line. To populate the description, tab through the service line.</p>
HCPCS	<p>This field is required.</p> <ul style="list-style-type: none"> ○ For inpatient bills, enter the accommodation rate. ○ For outpatient bills, enter the appropriate Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes. <p>To be as accurate as possible, various HCPCS and CPT® codes may require the use of modifiers.</p> <p><i>Use the appropriate modifier along with the procedure code.</i></p>

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Field Name	Field Description
Modifiers	<p>CPT code modifiers provide additional details regarding various services. Hospitals must use appropriate modifiers when billing for serious reportable events. If any services provided during that same day are reimbursable to bill those on a separate line.</p> <p>NOTE: <i>Institutional-based providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:</i></p> <ul style="list-style-type: none"> • QM - Ambulance service provided under arrangement by a provider of services; or • QN - Ambulance service furnished directly by a provider of services. While combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code, the reported modifiers can only indicate origin/destination. • FP- Family planning services are those provided to prevent or delay pregnancy or to otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes. • State Supplied Vaccines require the use of the SL modifier on both the administration code and the vaccine code.
DOS From/DOS To	<p>This field is required.</p> <p>Enter the beginning and ending dates of the period in which the service was provided.</p> <p>Dates must be entered in MM/DD/CCYY format. For example, February 14th, 2008 would be entered as "02/14/2008".</p> <p>NOTE: <i>Care should be taken when completing the "to" date as the system will default to the "from" date when billing for services that span a period (e.g. room and board days). If billing three units for room and board, the "to" and "from" dates must span three days. By not entering the appropriate "to" date information, the claim will deny. This instruction also applies to adjustment claims, as the system is currently defaulting to the "from" date for both fields.</i></p>

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Field Name	Field Description
Units	<p>This field is required.</p> <ul style="list-style-type: none"> For inpatient claims, enter the number of days of inpatient accommodations. <ul style="list-style-type: none"> Include the date of admission, but do not include the date of discharge. Units must equal the number of days in the “statement covers period” except on discharge claims. For outpatient claims, if the same service was provided more than once on the same day, enter the number of units provided. <ul style="list-style-type: none"> For example, if two EKGs were provided on the same day, enter two units. If the member is discharged, the total covered days is one less than the covered period. The number of covered days is reflected in the Value Codes area by using value code 80 and entering the number of days in the Amount field. All services— except inpatient and outpatient hospital—must bill no more than the number of days in one calendar month in a single DDE submission.
Charge	<p>This field is required.</p> <p>Enter the total charges pertaining to the related revenue code for the current billing period, as entered in the statement’s covered period.</p> <p>The system will add the dollar sign (\$) and will assume two decimal places unless specifically entered by the user.</p>
Non-Covered Charges	<p>If applicable, enter the non-covered charges pertaining to the related revenue code.</p> <p>If the claim contains an ICD diagnosis or procedure code for circumcision, then the charges related to the circumcision must be placed in the non-covered charges column.</p> <p>If the facility does not enter non-covered charges for the circumcision, do not put the ICD diagnosis or procedure code on the claim.</p> <p>If this field is completed and the charges are for non-covered days, the number of days must be reflected in the Value Codes area, in the Amount field, using Value Code 81- see Section 4.2.1: Complete the Claim Information Section for reference.</p> <p>The system will add the dollar sign (\$) and will assume two decimal places unless specifically entered by the user.</p>
Auth #	<p>If there is a Prior Authorization (PA) number for any service line, then enter the PA number in this field.</p>
National Drug Code (NDC)	<p>The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits.</p>

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Field Name	Field Description
Units of Measure	<p>Enter the NDC unit of measurement. The unit of measurement codes are:</p> <ul style="list-style-type: none"> • F2- International Unit • GR- Gram • ME- Milligram • ML- Milliliter • UN- Unit <p>The MIHMS Health PAS Online Portal allows providers to query procedure code/NDC combinations and NDC rebate information by specific dates. The online portal will then display valid J-Codes and NDC combinations for MaineCare. More information about this functionality is included in Appendix B: NDC-J-Code Lookup.</p>
Quantity/Units	<p>NDC units are based upon the numeric quantity administered to the patient and the unit of measurement (indicated in the Units of Measure field).</p> <p>Enter the actual metric decimal quantity administered in this field.</p>
Rx Number	<p>The Rx Number field should be used when the dispensing of the drug was done with a prescription number or when the dispensed drug involves the compounding of two or more drugs and there is no prescription number.</p> <p>If there is no prescription number, a “link sequence number” is reported, which is a provider-assigned number that is unique for the claim. The link sequence number matches the components, similar to the prescription number.</p>
Claim Header Total	<p>This field will automatically populate.</p> <p>This field provides a sum of the claim charges at the line level that is automatically calculated.</p>
Units	<p>This field will automatically populate.</p> <p>This field provides a sum of the number of service units billed at the service line level that is automatically calculated.</p>
Claim Line Total	<p>This field will automatically populate.</p> <p>This field provides the total of billed charges for the service line that is automatically calculated.</p>
Disallowance	<p>This field will automatically populate.</p> <p>This field displays the amount which is calculated by QNXT adjudication. It is the portion of the billed charges that is denied.</p>

NOTE: When a **Revenue Code** is entered, the description will appear in the **Service Code Description** box. The total price and total units will be totaled at the bottom right of this area.

When a **Service Code** is entered, the description will also appear below in **Current Procedure Terminology** in the **Service Code Description** box. The total price and total units will be totaled at the bottom right of this area.

The information displayed in the Service Code Description box is only for revenue codes entered in the Code field. Populating the HCPCS field will not alter the description showing in the Service Code Description field. Additionally, the Service Code Description box will only display information for one line at a time. To see the description for a different line, select the line by clicking in the populated Code field, and then press Tab.

4.2.5.1 Revenue/Service Code Search Function

Service Codes

☐ Enter NDC Codes

Line#	Code *	HCPCS	Modifier(s)	DOS From *	DOS To *	Units *	Charge *	Non-Covered Charges	Referral	NDC	Unit of Measure	Quant/Units	Price
1													

Service Code Description:

Click to search

Claim Header Total: 0
Units: 0
Claims Line Total: 0
Disallowed: 0

Figure 4-21: Institutional Services Section

To search for the **Revenue/Service Code**, click icon next to the **Line #**, as shown in [Figure 4-21](#) above, and a new search window will open.

To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the **Search** Button. Click the **Reset** button to clear the field and return all codes.

Service Codes

Description: **Search** **Reset**

Close Window

Figure 4-22: Revenue/Service Code Search

1. Enter any part of the description of the code in the **Description** field as shown in [Figure 4-22](#) above.
2. Click the **Search** button to get a list of results. The system will look for the text entered regardless of where it falls in the description.
 - To start over, click the **Reset** button to clear the **Description** field.
3. The Revenue/Service Code search results will display **Code IDs**, **Descriptions**, **Effective Dates**, and **Term Dates (if applicable)**. Click any **Code ID** link to populate the Code ID to the **Code** section as shown in [Figure 4-23](#) below.

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To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

Service Codes

Click Code ID

Description:

Code ID	Description	Effective Date	Term Date
3109	OTHER ADULT	4/1/2003	
2109	OTHER ALTHERAPY	4/1/2002	

Figure 4-23: Revenue/Service Code Search Results

4.2.6 Enter COB Information

The user may enter the information for Coordination of Benefits (COB) by selecting the **Enter COB Information** link below the Service Code area.

- The COB information may be entered either by Claim or by Service Line for any external totals to be applied. Information must be entered at the Service Line level when available on the Explanation of Benefits (EOB). When possible, enter detail at the Line Level for more accurate claims processing- see [Figure 4-24](#) below.

Enter External Totals to be applied as COB

Enter Medicare: ☐ by Claim ☒ by Service line

Choose this option for Medicare claims

Line #/Total	DOS	Allowed Amt	Paid Amt	Deductible Amt	Coinsurance Amt	Act Code
Total Medicare						
1						

Enter Commercial: ☐ by Claim ☒ by Service line

Choose this option for TPL claims

Line #/Total	Service Code	DOS	Allowed Amt	Paid Amt	Deductible Amt	Coinsurance Amt
Total Commercial						
1						

Figure 4-24: COB Information

- Choose the Medicare or Commercial option as appropriate- see [Figure 4-24](#) above.
 - If entering claims when Medicare C is primary, choose the Medicare option.
 - If entering claims for Third Party Liability (TPL), choose the Commercial option.
- The allowed amount should equal the sum of paid, deductible, and coinsurance amounts for both TPL and Medicare. The coinsurance amount will include copays.
- The Paid Date must be entered on the Coordination of Benefits screen when the claim is submitted as a secondary claim to MaineCare. Claims with no Paid Date will be denied.
- Click **Submit** to enter COB information.

NOTE: Enter detail at the line level for more accurate claims processing.

If entering COB information, the **Paid Amt**, **Deductible Amt**, and **Coinsurance Amt** fields must be populated. If the paid, deductible, or coinsurance amount is \$0.00, enter a "0" or "0.00" into the field.

The online portal will not allow the manual entry of the “\$” symbol when entering dollar amounts. Alternately, the provider may “tab through” the fields, and they will automatically populate with \$0.00.

If there is no Medicare Action Code (MAC) on the EOB, leave this field blank. If a MAC is noted on the EOB, the code(s) must be entered.

When submitting the EOB for Medicare Part C, the user must write “Medicare” on the top of the EOB for accurate claims processing.

*When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.*

4.2.7 Submit the Claim

When all the claim information has been entered, click **Submit** to submit the claim. Any errors in the application will be indicated at the top of the page in red text and must be corrected before the claim can be submitted.

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate.

4.3 Step 3 – The Claim Wizard Confirmation Screen

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate as shown in [Figure 4-25](#) below.

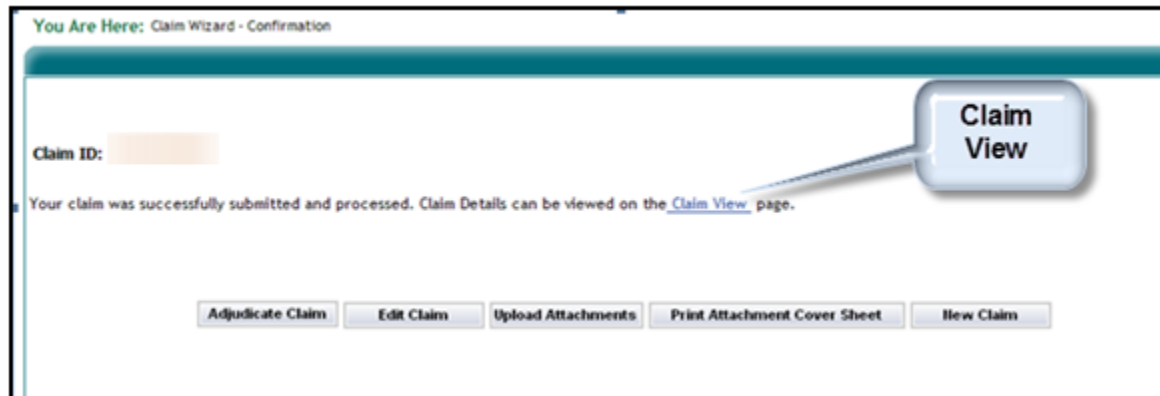


Figure 4-25: Claim Confirmation Screen

The **Claim ID** is automatically displayed on the confirmation screen. The Claim Wizard Confirmation screen also presents the following options:

- **Claim View:** Used to view a summary of the information that was entered into the claim (claim summary).
- **Adjudicate Claim:** Processes the submitted claim against the business rules to ready it for finalization.
- **Edit Claim:** Used to change claim information.
- **Upload Attachment:** Used to **attach** any **additional information** that is required to support the claim submission. Uploaded documents must be uniquely named. Without a unique name, the document will not overwrite another document of the same name. The result is the original attachment will now be inappropriately attached to the current claim.

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- Claims with COB information must have a corresponding EOB attached. When submitting a Medicare Part C EOB, be sure to write “Medicare” on the top of the EOB.
- Spenddown letters should be attached for each claim where the member has a coverage code of “Spenddown” for that particular date of service. Refer to [Section 4.3.4: Upload Attachments](#) for more information.

NOTE: Spenddown claims are entered via DDE according to the usual institutional claim entry instructions in this guide in [Section 4: Form Entry: Claim Submission](#).

- **Print Attachment Cover Sheet:** Select to print a cover sheet for the attachment.
- **New Claim:** Used to create a new claim.

4.3.1 Claim View

Clicking the **Claim #** hyperlink reveals the original claim. [Figure 4-26](#), below, is an example of a claim view.

Details for the selected claim appear below.

Claim Summary

Form Type: UB04

Status: **OPEN**

Claim #:

Member ID:

Member Name:

Address:

Patient Account #:

Medical Record #:

Service Provider:

Pay To Provider:

Dates of Service: 12/1/2013 - 12/1/2013

Attending Physician: NO PROVIDER

Date Processed: 12/10/2013

Check #:

Check Date:

Service Location:

Covered Days:

Life-time Reserved:

Non Covered Days:

Co-insured Days:

☐ Missing Information Indicator

Additional UB04 Detail

Type of Bill: 0111

Admit Date:

Status Code:

Admit Hour: 0

Source:

Discharge Hour: 0

Medical Rec #:

Type:

DRG:

Reimbursement Detail

Claim Total: \$100.00

Copay Applied: \$0.00

Allowed Amt: \$0.00

Deductible Applied: \$0.00

Eligible Amt: \$0.00

Coinsurance Applied: \$0.00

Paid Amt: \$0.00

Disallowed: \$0.00

Interest Days: 0

Cost of Care: \$0.00

Withhold Amt: \$0.00

Admt Responsibility: \$0.00

Paid(net Withhold) Amt: \$0.00

Total Patient Responsibility: \$0.00

COB Allowed: \$10.00

COB Paid: \$10.00

Refund Amt: \$0.00

Diagnosis Codes

Code	Description
010.16	TB pleurisy, primary, other confirmation

<- Prev Next ->

More Codes

Covered, Non-Covered, Coinsurance and Lifetime Reserve Days are listed as Value Codes. Select the More Codes link to view Procedure, Condition, Occurrence, Occurrence Span and Value codes.

Services

Service Line	Service Date	Rev Code	Description	HCPCS/ NDC	Approved	Modifier(s)	Billed Units	Billed Amount	Paid Amount	Detail
1	12/1/2013	0849	CAPD/HOME/OTHER				1.00	\$100.00	\$0.00	Details

<- Prev Next ->

Remittance Comments

No comments were found for this claim.

Claim Edit

No Edits were found for this claim.

Return to Claim Status

Adjudicate Claim

Reverse

Add Attachments

Figure 4-26: Claim View

View the details of a specific service line by clicking on the **Details** link at the end of that service line as shown above in [Figure 4-26](#). An example of the service line detail is depicted in [Figure 4-27](#) below.

The screenshot displays the 'My Health PAS' interface. At the top, a breadcrumb trail reads 'You Are Here: Claims > View Claim > View Claim Line'. Below this, a message states 'Details for the selected claim service line appear below:'. The 'Claim Summary' section includes fields for 'Claim #:', 'Health Plan ID:', 'Member Name:', and 'Dates of Service: 9/25/2013 - 9/25/2013'. The 'Status' is 'PEND' and the 'Service Provider' is listed. The 'Service Line Details' section shows 'Service Line: 1', 'Status: OKAY', 'Service Date: 9/25/2013', 'Rev Code: 0722', and 'Description: DELIVERY ROOM'. It also lists 'HCPCS: DELIVERY ROOM', 'NDC Codes', 'Approved', 'Modifiers', 'Billed Unit(s): 1.00', 'Auth ID', 'UM Approved Unit(s): 0', and various 'Amt' fields (Billed, Allowed, Eligible, Outlier, Paid, Withhold, Paid/Net Withhold, Cost of Care, Patient Responsibility, Pre-Paid) all set to \$0.00. A checkbox for 'Missing Information Indicator' is present. At the bottom, there is a 'Significance Comments' section with a 'Comment' field and a 'Return to Claim' button. Navigation links 'Previous' and 'Next' are also visible.

Figure 4-27: Service Line Details

After viewing the claim, the user may Adjudicate or Reverse it, Add Attachments, or Return to Claim Status by using the buttons at the bottom of the screen as shown in [Figure 4-28](#) below.

This screenshot shows a row of four buttons: 'Return to Claim Status', 'Adjudicate Claim', 'Reverse', and 'Add Attachments'.

Figure 4-28: Claim Functions

NOTE: If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.

4.3.2 Adjudicate Claim

The **Adjudicate Claim** button on the confirmation page initiates the claim adjudication process and sends the claim through predefined edits for real-time claims processing.

By viewing the status of the adjudication, the user can see if a claim has been successfully processed. If the claim fails to adjudicate, an error message will appear that reads, “Warning: There are Outstanding Edits” as shown in [Figure 4-29](#) below. The edits that caused the claim to fail adjudication will display under the Outstanding Edits header- see [Table 4](#) below for a list of Claim Statuses.

A claim on the portal can be adjudicated up to 10 times. The message at the top of the screen reading "Number of online adjudication attempts: x" keeps a running count.

Claims may have edits posted that indicate if the edit is a warning, denial, or pend. **A warn edit does not prevent a claim from paying.**

The screenshot displays the 'Claim Information' section of the portal. At the top, a red warning message states 'Warning: There are Outstanding Edits' with a callout bubble labeled 'Warning'. Below this, it shows 'Number of online adjudication attempts: 1'. The claim details include: Claim Type: UB04, Claim #: [redacted], Log Date: 9/26/2013, Member ID: [redacted], Member Name: [redacted], Address: [redacted], Dates of Service: 9/23/2013 - 9/23/2013, Billing Provider: [redacted], Patient Account #: [redacted], Medical Record #: [redacted], Prior Auth: [redacted], Date of Birth: [redacted], Rendering Provider: [redacted], and Referring Provider: [redacted]. A callout bubble labeled 'Click to Edit' points to the 'Edit Claim' button. Another callout bubble labeled 'Edits' points to the 'Outstanding Edits' table. The table has columns for Line #, Edits, Description, Status, and Category. The first row shows Line # 1, Edits 150, Description 'No contract term found for service', Status 'DENY', and Category 'CONTRACT'. At the bottom, there are buttons for 'Edit Claim', 'Add Attachments', 'Print Attachment Cover Sheet', and 'New Claim'.

Figure 4-29: Adjudicate Claim

After adjudication, the user may add attachments by selecting **Add Attachments**- see [Figure 4-30](#) below.

The screenshot shows a horizontal navigation bar with four buttons: 'Return to Claim Status', 'Adjudicate Claim', 'Reverse', and 'Add Attachments'. The 'Add Attachments' button is highlighted with a red rectangular border.

Figure 4-30: Add Attachments

4.3.3 Edit Claim

Clicking the **Edit Claim** button opens the claim that was just submitted and offers the option to edit the claim and add or delete parts of the claim as needed before adjudicating the claim again.

Upon completion, three buttons offer further options: **Back**, **Save**, **Adjudicate** as shown in [Figure 4-31](#) below.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.

The screenshot shows three buttons arranged horizontally: 'Back', 'Save', and 'Adjudicate'. Each button is a light blue rectangle with a thin border and a slight shadow.

Figure 4-31: Back, Save, Adjudicate Buttons

4.3.4 Upload Attachments

Attachments may be uploaded from the **Claims Status** window, by clicking the **Add Attachments** button. A new window will appear as shown in [Figure 4-32](#) below.

You Are Here: Add Attachments

Claim Number: [Redacted] Type: 1500
Provider Name: [Redacted]
Member Name: [Redacted] Claim Status: PEND
Date of Service: [Redacted]

Attachments

Type of Attachment: X-ray (Drop-down Menu)
File Format: Valid file formats are: GIF, JPEG, MS Excel, MS Word, PDF, TIFF
[Text Field] (Browse Local Machine) [Browse...]
[Attach] [Cancel]

Figure 4-32: Upload Attachments

Claim information is pre-populated on the top of the page. To add an attachment, follow the steps below:

1. Click the drop-down menu to select the **Type of Attachment** that will be added.
2. Select the **Browse** button to locate the file on the local computer. All supporting document files must be in one of these formats: GIF, JPEG, MS Excel (.xls), MS Word (.doc), PDF, and TIFF.
3. Click the **Attach** button when the file to upload is listed in the **Browse** field.
4. Attachments may be uploaded through the portal for claims previously submitted via EDI or paper by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim. See [Section 5: Claim Status](#) for more information on searching for claims by claim status. Attachments should be submitted on the same day. If the appropriate attachment is not present when a claim is being reviewed, it will deny.
 - If the user is unable to upload required attachments, claims should be submitted on paper with the appropriate attachment.

NOTE: If users are unable to upload electronic copies of attachments, fill out the **Cover Sheet for Claims** found on the Provider Page>Provider Documents>Forms> Claims. Be sure to include the **Claim number** provided on the confirmation screen. Send the cover sheet along with all mailed documents. If the appropriate attachment is not present when the claim is reviewed, the claim will deny.

Mail to:

Claims Unit- Attachments
Office of MaineCare Services
11 State House Station
Augusta ME 04333-0011

5. Claim Status

To check the status of a claim, follow the steps below:

1. Select the **Claim Status** link under the **Form Entry** heading to access the claim status screen, as shown in [Figure 5-1](#) below.

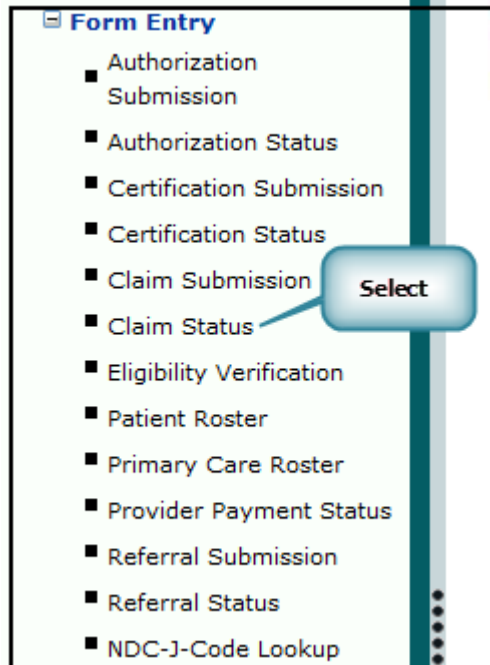


Figure 5-1: Selecting Claim Status on Form Entry

2. Select the proper provider from the **Billing Providers** drop-down menu. Claims associated with the selected Billing Provider will be displayed below the drop-down menu, under claim status- see [Figure 5-2](#) below for reference.

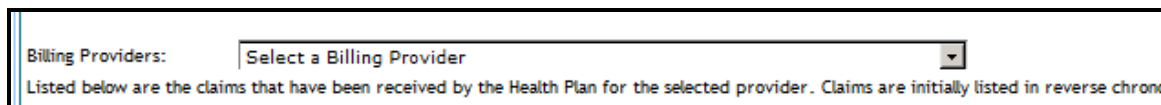


Figure 5-2: Select Provider Drop-down

3. The search results for that Billing Provider are shown in the order of the newest to the oldest claims. Clicking on any underlined column heading will sort the lines according to the values in that column. To view claims in greater detail, click the **Claim #** link as shown in [Figure 5-3](#) below.

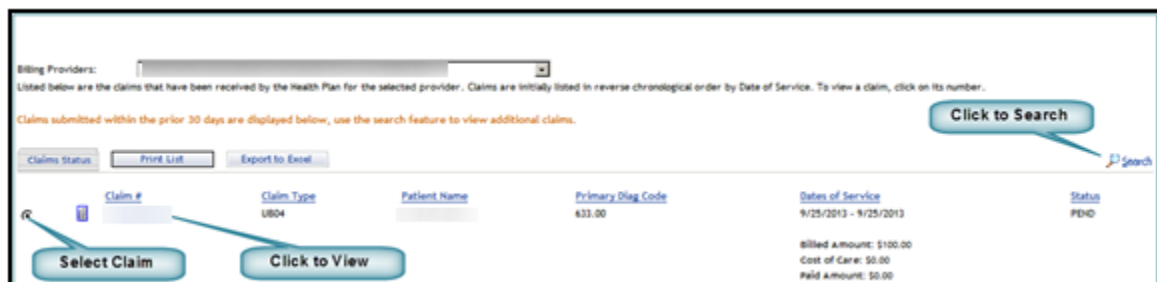


Figure 5-3: Claim Status Screen

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4. Claim status identifies the processing stage of the claim. [Table 4](#) below, groups the statuses into three categories: **Initial**, **Awaiting Payment**, and **Finalized**. Claims with an initial status of “Rev” or “Rev Synch” may not be edited. Claims with any other initial status may be edited by the provider. Claims in Finalized status of Paid may be Reversed or Replaced.

NOTE: *If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.*

See [Table 4](#) below for more detailed explanation of the claim statuses.

Table 4: Claim Statuses

Claim Statuses	
Initial Claim Statuses	
Open	The claim has been entered with the required fields for submission.
Adjudicated	The claim has been processed against the business rules of the system.
Deny	The claim has failed the adjudication process.
Pay	The claim has passed the adjudication process and is ready to be submitted for payment.
Pend	The claim has been set aside for review to determine if it should be paid or denied.
Rev	The claim is an inverse of a previously paid claim that is created to take away any payment error.
Rev synch	The REV claim is held in this status until the companion replacement claim moves to Pay or Deny.
Awaiting Payment Claim Statuses	
Wait deny	Awaiting the finalization of the claim denial for inclusion on the remittance advice.
Wait pay	Awaiting the finalization of the claim payment submitted to AdvantageME for inclusion on the check and remittance advice.
Wait rev	Awaiting the finalization of the claim reversal for inclusion on the check and remittance advice.
Finalized Claim Statuses	
Paid	The payment process is complete and is included in a Remittance Advice.
Denied	The claim has failed the adjudication process, has been denied, and is included in a Remittance Advice.
Reversed	The negative claim has been finalized and is included in a Remittance Advice.
Void	May be created as part of a mass adjustment (reversal and replacement) to void the replacement (adjustment) claim when only a reversal should have occurred. These transactions do not appear on a remittance advice or in an 835. They are administrative transactions only.

5. To select a claim, click the radio button as shown in [Figure 5-3](#) above. The user can perform the following actions on selected claims: Edit, Adjudicate, Add Attachments, Reverse, Print Attachment Coversheet, or Print- see [Figure 5-4](#) below.




Figure 5-4: Claim Standard Buttons

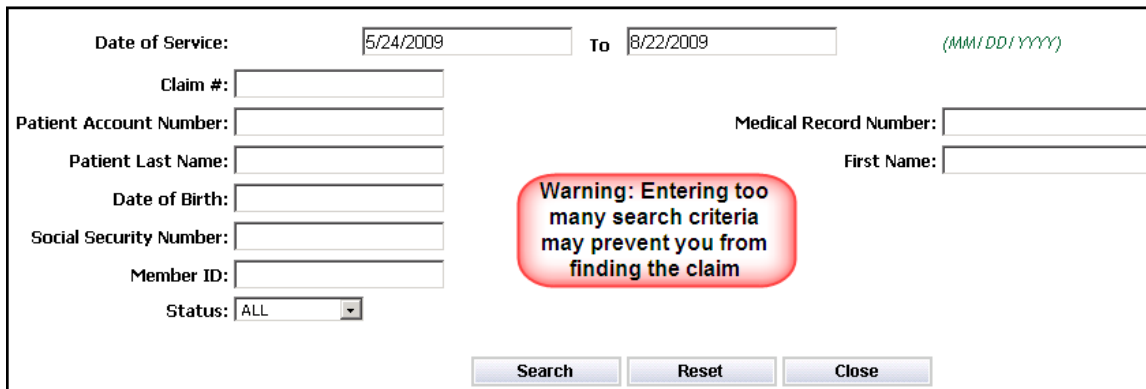
5.1 View a Claim

To view a claim, see [Section 4.3.1: Claim View](#) above.

5.2 Search Claim

To search for a specific claim:

1. Click the  icon, shown in [Figure 5-3](#) above.
2. Searches may be performed on any of the fields available as shown in [Figure 5-5](#) below.
 - a. The dates entered in the **Date of Service From** and **To** fields must be fewer than 90 days apart.
 - b. The **Search** button finds the claim(s).
 - c. The **Reset** button clears all the values.
 - d. The **Close** button closes the search area.



Date of Service: To (MM/DD/YYYY)

Claim #:

Patient Account Number: Medical Record Number:

Patient Last Name: First Name:

Date of Birth:

Social Security Number:

Member ID:

Status:

Warning: Entering too many search criteria may prevent you from finding the claim

Figure 5-5: Claim Search

5.3 Edit Claim

Claims with an initial status of “Rev” or “Rev Synch” **may not be edited**. Claims with any other initial status may be edited. Refer to [Table 4](#) above, for the list of initial statuses. Claims with a finalized status of “Reversed” or “Void” cannot be reversed or replaced. “Denied” claims cannot be reversed and should be rebilled.

- Claims listed as "Open", "Adjudicated", "Pay", "Pend", “Rev”, or "Deny" have not been finalized.
- Claims listed as "Paid". “Reversed”, or "Denied" have been finalized (processed through the payment cycle).

Click the option button in front of the claim to select it for editing. Click **Edit** to edit the claim, as shown in [Figure 5-6](#) below.

For additional information about editing a claim see [Section 4.3.3: Edit Claim](#).

NOTE: If an attempt is made to Reverse or Replace a claim, that is not Finalized, a standard error message will appear “Cannot Reverse/Replace a Claim that is not Paid or Denied”.

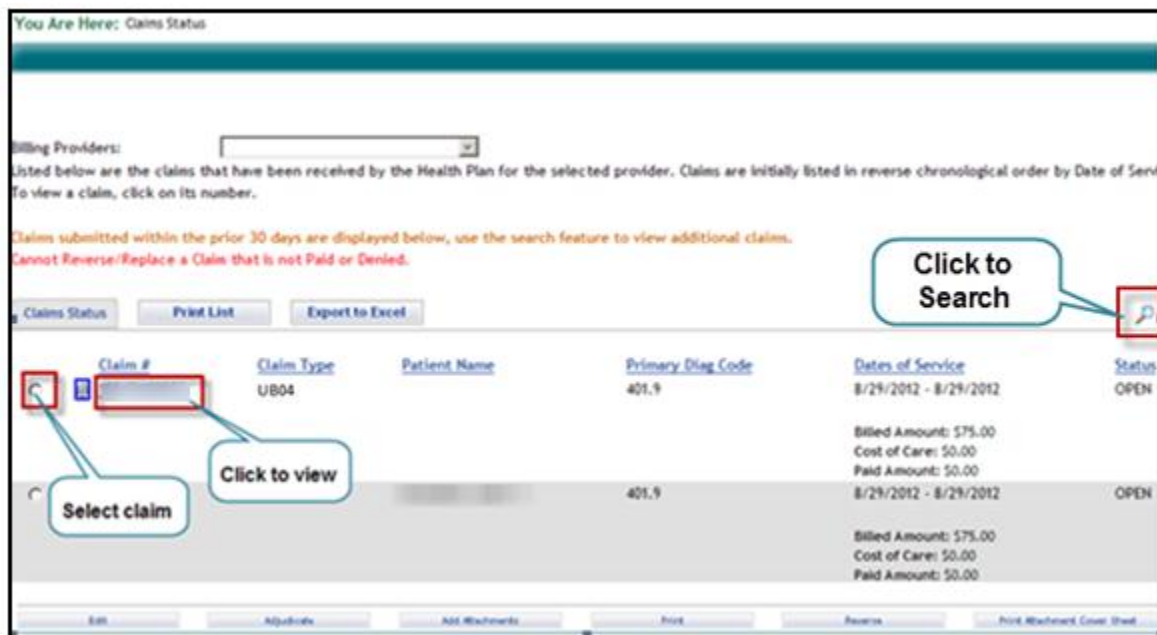


Figure 5-6: Edit Claim

Upon completion, three buttons offer further options: **Back**, **Save**, **Adjudicate**, as shown in [Figure 5-7](#) below.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.



Figure 5-7: Claim Edits Options

5.4 Adjudicate Claim

To adjudicate a claim, see [Section 4.3.2: Adjudicate Claim](#).

5.5 Reversing a Paid Claim

The user may reverse and replace any finalized **Paid** claim. Users may also simply reverse the claim.

- A **Reverse** transaction reverses everything on the claim; the charged amount, payment and the units/visits, etc. are negated.
- During the **Replace**, the claim data will be pre-populated. Users will have the option of changing the data prior to resubmission.

NOTE: When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.

NOTE: When a reversal claim is submitted, and is in a status of “Rev” or “Rev Synch”, the **Edit** and **Adjudicate** buttons at the bottom of the Claim Status screen will be greyed out.

- The Original Claim, the Reversal Claim and/or the Replacement Claim will be visible in the system. This is for accounting purposes and will show on the next Remittance Advice.

To reverse or reverse and replace a claim, follow these steps:


1. Search for a claim by clicking the  icon, as shown in [Figure 5-6](#) above.
2. Select a claim.
3. Select **Reverse** on the claim status page as shown in [Figure 5-8](#) below.



Figure 5-8: Reverse a Claim

4. On the next screen, select the option to **Reverse this claim and create a new claim**.

NOTE: To reverse a claim without creating a replacement claim, select the option to **Reverse this claim only**.

5. Preserve the existing data by checking the box next to **Use the data from this claim as basis for the new claim**. The new claim will have all applicable data copied over, as shown in [Figure 5-9](#) below.

The screenshot shows a web application window titled "My Health PAS". The breadcrumb trail is "Provider Home > MHP Viewer". The page title is "You Are Here: Claims Status-Reverse Claim". A tab labeled "Reverse Claim" is active. The form displays the following claim information:

- Claim Number: [redacted]
- Claim Type: 1500
- Member Name: [redacted]
- Diagnosis Code: v82.1
- Dates of Service: 3/22/2010 - 3/22/2010

Below the claim information, the text "Select the desired option:" is followed by three radio button options:

- ☐ Reverse this claim and create a new claim
- ☒ Use the data from this claim as the basis for the new claim
- ☐ Reverse this claim only

A blue callout bubble with the text "To preserve existing data" points to the second option. At the bottom of the form are two buttons: "Continue" and "Cancel".

Figure 5-9: Claim Status–Reverse Claim

6. Click OK when the verification question pops up, as shown in [Figure 5-10](#) below.

7. If reversing and replacing the claim, the portal will automatically navigate to a claim edit screen where the replacement claim information may be updated.

The screenshot shows the 'Reverse Claim' interface. At the top, there's a 'Trading Partner' header and a breadcrumb trail: 'Provider Home > MHP Viewer > My Health PAS'. Below this, a status bar indicates 'You Are Here: Claims Status-Reverse Claim'. The main form area has a 'Reverse Claim' tab selected. It contains several input fields: 'Claim Number', 'Claim Type' (set to 1500), 'Member Name', 'Diagnosis Code' (set to v82.1), and 'Dates of Service' (set to 3/22/201). Below these fields, there's a section titled 'Select the desired option:' with three radio buttons: 'Reverse this claim and create a new claim' (selected), 'Use the data from this claim as the basis for the new claim' (checked), and 'Reverse this claim only'. A modal dialog box from 'Microsoft Internet Explorer' is open in the center, displaying a question mark icon and the text 'Are you sure you want to reverse?' with 'OK' and 'Cancel' buttons. At the bottom of the main form, there are 'Continue' and 'Cancel' buttons.

Figure 5-10: Verification Question

8. After the revisions are completed, the replacement claim can be adjudicated with the updated data.

NOTE: The updated information must be saved by selecting *Save*, as shown in [Figure 5-11](#) below, before the claim can be adjudicated.

The screenshot shows the 'Additional Information' section of the claim form. It has a sub-header 'Additional Information'. Below it, there's a section 'Is Patient Condition Related To' with three checkboxes: 'Employment', 'Auto Accident', and 'Other Accident'. Below these is a 'State:' dropdown menu. Then, there's a 'Date of Accident:' field with a date picker showing 'MM/DD/YYYY'. Below that is a 'Miscellaneous' section with two checkboxes: 'Is Orthodontics' and 'Initial Prosthesis'. Below 'Is Orthodontics' are two fields: 'Date Appliance Placed:' (MM/DD/YYYY) and 'No. of Months Remaining:'. Below 'Initial Prosthesis' is a 'Prior Prosthesis Date:' field (MM/DD/YYYY). At the bottom of the form, there are three buttons: 'Back', 'Save' (highlighted with a red box), and 'Adjudicate'.

Figure 5-11: Save Updated Information

- A **Reversed** Claim will have an R1 (or sequential number) at the end of the Claim number.
- A **Replaced** Claim will have an A1 (or sequential number) at the end of the Claim number- see [Figure 5-12](#) below for reference.
 - The Replaced Claim will require a new Patient Account # since it is a new claim.

Trading Partner

Provider Home > MHP Viewer

My Health PAS

You Are Here: Claim Edit

Claim is successfully Reversed and Replaced Reversal Claim ID is .R1

Claim Information

Claim Type: 1500	Billing Provider:
Status: OPEN	Patient Account # :
Claim #:	Medical Record #:
Log Date: 4/1/2010	Prior Auth:
Member ID:	Date of Birth:
Member Name:	Rendering Provider * :
Address:	Referring Provider: NO PROVIDER
Dates of Service: 3/22/2010 - 3/22/2010	Service Location * :

Figure 5-12: Successfully Reversed and Replaced Claim Screen

Users may also choose to **reverse a claim without creating a replacement claim** by selecting the **Reverse this Claim Only** option in step 3.

- A Reversal transaction reverses everything on the claim. The charged amount, the payment and the units/visits, etc. will be negated.
- A Reversed Claim will have an R1 (or sequential number) at the end of the Claim number.

[Figure 5-13](#) below, provides an example of a successfully reversed claim.

NOTE: It is not necessary to click on **Continue** once users receive this reversal confirmation screen. Clicking on **Cancel** will bring the user back to the Claim Status page.

Reverse Claim

Claim Number: [REDACTED]

Claim Type: UB04

Member Name: [REDACTED]

Diagnosis Code: [REDACTED]

Dates of Service: 10/22/2013 - 10/22/2013

Select the desired option:

☐ Reverse this claim and create a new claim

☐ Use the data from this claim as the basis for the new claim

☒ Reverse this claim only

Reversal ClaimId : [REDACTED] **R1**

Claim is successfully Reversed

Continue **Cancel**

Figure 5-13: Successfully Reversed Claim Screen

Appendix A: Additional Revenue Code Information

Appendix A contains detailed information regarding how to populate the Code field in the Service Codes section.

Alternative Residential Facilities:

- Bill revenue code 3104 (Charges must reflect the appropriate Resource Rate. See [Table 5](#) below for reference.)
 - This revenue code does not require a procedure code in the HCPCS field.

Table 5: Resource Rate

Resource Group	MaineCare Weight	Resource Adjusted Price (Based on \$43.26 Unadjusted Price Multiplied by MaineCare weight)
1	1.657	\$71.68
2	1.210	\$52.34
3	1.360	\$58.83
4	1.027	\$44.43
5	.924	\$39.97
6	.804	\$34.78
7	.551	\$23.84
8	.551	\$23.84

Revenue code- 0169 Room and Board:

- This revenue code does not require a procedure code in HCPCS field.
- In the Charges field, a facility less than five years old should bill \$1012.
- In the Charges field, a facility greater than five years old should bill \$787.

Case Mix Nursing Facilities Billing:

- Bill the 0169 revenue code for the non-case mix element (direct care add-on, routine and fixed).
- Bill 0022 revenue with HCPCS RUG codes listed in [Table 6](#) below.
 - The billing HCPCS RUG code will use the three characters RUG III Group (e.g., RUC) and the two digit extension “00”.
- For leave days, facilities will bill the following two leave revenue codes when a resident is out of the facility and expected to return:
 - Revenue Code 0185 – Used when a Nursing Home member is hospitalized.
 - Revenue Code 0183 – Used for Therapeutic leave, ex. Home visits

Excluded Nursing Facilities – Contracted Facilities:

- Revenue Code – 0128 – Used for Brain Injury
- Revenue Code – 0124 –Used for Mental Health
- Revenue Code – 0169 – Remote Island
- All Contracted facilities will bill the following leave revenue codes when a resident is out of the facility and expected to return:
 - Revenue Code 0180 – General leave of absence
 - Revenue Code 0182 – Patient Convenience, ex. Home visits
 - Revenue Code 0185 – Used for Remote Island General leave of absence (for hospitalizations).
 - Revenue Code 0183 – Used for Remote Island Patient Convenience, ex. Home visits

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Table 6: RUG Table

Order	Hierarchy	RUG Group	HCPSC RUG Code	Description	Weight 512ME
1	Rehab	RUC	RUC00	REHAB ULTRA/ADL 16-18	1.986
2	Rehab	RUB	RUB00	REHAB ULTRA/ADL 9-15	1.426
3	Rehab	RUA	RUA00	REHAB ULTRA/ADL 4-8	1.165
4	Rehab	RVC	RVC00	REHAB VERY HI/ADL 16-18	1.756
5	Rehab	RVB	RVB00	REHAB VERY HI/ADL 9-15	1.562
6	Rehab	RVA	RVA00	REHAB VERY HI/ADL 4-8	1.217
7	Rehab	RHC	RHC00	REHAB HI/ADL 13-18	1.897
8	Rehab	RHB	RHB00	REHAB HI/ADL 8-12	1.559
9	Rehab	RHA	RHA00	REHAB HI/ADL 4-7	1.260
10	Rehab	RMC	RMC00	REHAB MED/ADL 15-18	2.051
11	Rehab	RMB	RMB00	REHAB MED/ADL 8-14	1.635
12	Rehab	RMA	RMA00	REHAB MED/ADL 4-7	1.411
13	Rehab	RLB	RLB00	REHAB LOW/ADL 14-18	1.829
14	Rehab	RLA	RLA00	REHAB LOW/ADL 4-13	1.256
15	Extensive	SE3	SE300	EXTENSIVE 3/ ADL 7-18/TBI-ADL 15-18	2.484
16	Extensive	SE2	SE200	EXTENSIVE 2/ADL 7-18/TBI-ADL 10-14	2.057
17	Extensive	SE1	SE100	EXTENSIVE 1/ADL 7-18/TBI-ADL 7-9	1.910
18	Special Care	SSC	SSC00	SPECIAL CARE /ADL 17-18	1.841
19	Special Care	SSB	SSB00	SPECIAL CARE/ADL 15-16	1.709
20	Special Care	SSA	SSA00	SPECIAL CARE/ADL 4-14	1.511
21	Clinically Comp	CC2	CC200	CLIN. COMP W/DEP/ADL 17-18	1.826
22	Clinically Comp	CC1	CC100	CLIN. COMP/ADL 17-18	1.663
23	Clinically Comp	CB2	CB200	CLIN. COMP W/DEP/ADL 12-16	1.503

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Order	Hierarchy	RUG Group	HCPSC RUG Code	Description	Weight 512ME
24	Clinically Comp	CB1	CB100	CLIN. COMP/ADL 12-16	1.389
25	Clinically Comp	CA2	CA200	CLIN. COMP W/DEP/ADL 4-11	1.331
26	Clinically Comp	CA1	CA100	CLIN. COMP/ADL 4-11	1.149
27	Cognitively Imp	IB2	IB200	COG. IMPAIR W/RN REHAB/ADL 6-10	1.199
28	Cognitively Imp	IB1	IB100	COG. IMPAIR/ADL 6-10	1.152
29	Cognitively Imp	IA2	IA200	COG. IMPAIR W/RN REHAB/ADL 4-5	0.945
30	Cognitively Imp	IA1	IA100	COG. IMPAIR/ADL 4-5	0.888
31	Behavioral	BB2	BB200	BEHAVE PROB W/RN REHAB/ADL 6-10	1.180
32	Behavioral	BB1	BB100	BEHAVE PROB/ADL 6-10	1.123
33	Behavioral	BA2	BA200	BEHAVE PROB/ W/RN REHAB/ADL 4-5	0.905
34	Behavioral	BA1	BA100	BEHAVE PROB/ ADL 4-5	0.759
35	Physical	PE2	PE200	PHYSICAL W/RN REHAB/ADL 16-18	1.454
36	Physical	PE1	PE100	PHYSICAL /ADL 16-18	1.421
37	Physical	PD2	PD200	PHYSICAL W/RN REHAB/ADL 11-15	1.323
38	Physical	PD1	PD100	PHYSICAL/ADL 11-15	1.281
39	Physical	PC2	PC200	PHYSICAL W/RN REHAB/ADL 9-10	1.219
40	Physical	PC1	PC100	PHYSICAL/ADL 9-10	1.088
41	Physical	PB2	PB200	PHYSICAL W/RN REHAB/ADL 6-8	0.833
42	Physical	PB1	PB100	PHYSICAL/ADL 6-8	0.854
43	Physical	PA2	PA200	PHYSICAL W/RN REHAB/ADL 4-5	0.776
44	Physical	PA1	PA100	PHYSICAL /ADL 4-5	0.749
45	Not Classified	BC1	AAA00	NOT CLASSIFIED	0.749

Appendix B: NDC-J-Code Lookup

The MIHMS Health PAS Online Portal allows providers to query procedure code/NDC combinations and NDC rebate information by specific dates. The online portal will then display valid J-Codes and NDC combinations for MaineCare- see [Figure 5-14](#) below. A list of the parameters required to perform an NDC-J-Code Lookup is provided in [Table 7](#) below.

DISCLAIMER: The information used in this lookup is periodically updated; therefore, no guarantee of claim payment is expressed or given.

Provider Home > MHP Viewer

Account Maintenance
File Exchange
Form Entry
 Authorization
 Submission
 Authorization Status
 Certification Submission
 Certification Status
 Claim Submission
 Claim Status
 Eligibility Verification
 Patient Roster
 Primary Care Roster
 Provider Payment Status
 Referral Submission
 Referral Status
 NDC-J-Code Lookup
Provider Enrollment Links
Prior Authorizations
Training
 Registration in Learning Management System
 Learning Management System
TP Documents
Provider Lists
 Frequently Asked Questions
 Provider Directory
Surveys
 OnLine Website Survey
Contact Us
Site Map

Select

Enter Inquiry Date along with NDC and/or J-Code to perform the search. The information on these files is periodically updated, therefore, no guarantee of claim payment is expressed or given.

Inquiry Date: 03/27/2015
NDC: 00781932785
J-Code: J1050
Submit Reset

Disclaimer

NDC Details

NDC: 00781932785
Rebateable: YES
Product Name: CEFTRIAXONE SODIUM
Generic Name: Ceftriaxone Sodium For Inj 500 MG
Labeler: NOVAPLUS/SANDOZ

Valid J-Code

J-Code(s) below are valid for this NDC for the date requested. The information on these files is periodically updated, therefore, no guarantee of claim payment is expressed or given.

J-Code	Description
J1050	INJECTION, MEDROXYPROGESTERONE ACETATE, 1 MG

JCode Detail

J-Code: J1050
HCPCS Description: INJECTION, MEDROXYPROGESTERONE ACETATE, 1 MG

Valid NDC

NDC(s) below are valid for this J-Code for the date requested. The information on these files is periodically updated, therefore, no guarantee of claim payment is expressed or given.

NDC	Product Name	Labeler	Rebateable
00781932785	CEFTRIAXONE SODIUM	NOVAPLUS/SANDOZ	YES

Figure 5-14: NDC J-Code Lookup

Table 7: NDC J-Code Lookup Parameters

Field Name	Field Description
Inquiry Date	Enter the Inquiry Date to be used for validation of the information provided. <ul style="list-style-type: none">• Dates must be entered in MM/DD/CCYY format. For example, February 14, 2015 would be entered as “02/14/2015”:• Cannot be a future date• Can be selected with the calendar option• Must be provided for valid combinations to be confirmed
NDC	Enter a valid 11 digit NDC Code <i>NOTE: To see both the Product Name and the generic labeling enter only the NDC code.</i> This tool uses multiple sources of data for validation: Medispan; CMS and Noridian which may cause differences in how the labelers name is displayed. In addition, the name of the NDC labeler could change and result in listing a different name. The intent of this tool is to confirm the validity of the J-code/NDC combination for a specific date.
J-Codes	Enter a valid 5 character J-Code